Kennedy

005003

INVESTIGATION INTERVIEW SCHEDULE

1. Identifying Information:

Name Dr. C. James Carrico
Address Harbor View Medical Center
City/State Seattle, Wash
Date of Birth
Social Security

Date Jan 11, 1978
Place Harbor View Medical Center
Telephone
M or S
Spouse
Children

2. Physical Description:

Height
Weight
Ethnic Group

Color Eyes Hair
Special Characteristics

3. ersonal History:

a. Present Employment:
Address
Telephone

b. Criminal Record
1. Arrests
2. Convictions

4. Additional Personal Information:

a. Relative(s): Name
Address

b. Area frequented:
c. Remarks:

Andy Purdy Mark Flanagan

Investigator Andy Purdy and Mark Flanagan

Date January 23, 1978 Form #4-B

DATE: January 11, 1978

TIME: 2:55 p.m.

PLACE: Seattle, Washington
Harbor View Medical Center

STAFF PRESENT: Andy Purdy, Staff Counsel
Mark Flanagan, Staff Researcher

INTERVIEWEE: Dr. James Carrico

KEY: C - Dr. Carrico
P - Purdy/Flanagan

P: Dr. Carrico, we have just been discussing the events of November 22, 1963, and your treatment of President Kennedy and in some detail, the nature of the wounds for approximately the last hour. Is that correct?

C: That's correct.

P: For the record, could you please state what your present position is.

C: I'm Professor of Surgery at the University of Washington and Surgeon Chief at Harbor View Medical Center which is one of the University of Washington teaching hospitals.

P: How much experience in treating gunshot have you had since 1963?

C: One of my interests has remained the management of trauma and I would estimate I've seen roughly 60 to 75 gunshot wounds a year since that time.

P: Could you please describe the condition of President Kennedy when you first saw him in the Trauma Room at Parkland Hospital and begin in some detail, a description of those wounds and the work you performed.

C: When I first saw him, he could best be described as agonal, his color was ashen blue-gray, respiration, he did have spontaneous respirations, they were irregular, spasmodic and not very effective. The nurse reported that he didn't have a blood pressure. I listened to his chest very briefly. He had some irregular sounds which I interpreted as heart sounds. There was some urgency to establish that he had two obvious wounds, one in the anterior neck, just to the right of the trachea just below the larynx. From that wound was issuing foamy blood, mostly air, some blood with each attempt at respiration. The other wound was a fairly large wound in the right side of the head, in the parietal , occipital area. One could see blood and brains,both cerebell/um and cerebrum fragments in that wound. The area was the most urgent item and I successfully passed an oral, endotracheal tube by mouth. I noticed at that time probably some deviation of the trachea to the left, very slight, some modest amount of hematoma in the recesses to the right of the trachea. The/endotrachealtube was passed, the balloon was inflated, and we were able to then maintain adequate ventilation, although there was still some leak around the hole in the anterior neck. By that time, several other physicians had arrived, and I directed my attention to establishing more intravenous fluids,/and administration of fluids and medications while they continued to work on the .

P: Upon your first examination of the anterior neck wound, was there any material going in or out of that wound?

C: Air. You could tell there was air going in and out because the foamy material was issuing back and forth and you could hear the air going in and out.

P: Could you describe this movement of material as a bubbling effect -- what did that material consist of?

C: Mostly air bubbles of foamy blood.

P: In describing the foam that you saw when you placed the endotracheal tube, where was that foam coming from? Was it coming from between the vocal cords?

C: Yes it was coming up - there was some foam between his cords and a little bit of air coming out.

P: Could you describe as best you can how the wound in the anterior neck looked?

C: My total recollection of that wound was of a small, fairly circular wound, with material issuing from it. And that's really my total recollection.

P: Based on your examination of that wound, are you able to tell us anything about the direction in which whatever object caused the wound had been passing? Were you able to determine what the nature of the object had been which had caused the wound?

C: Not for sure.

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P: What was your belief?

C: It looked like a bullet.

P: Was it your sense that it was a full bullet or a bullet fragment?

C: I would have no idea.

P: Was it your impression that the bullet that you felt had caused the wound had been traveling straight, was there a slight tumble, or was there a significant tumble to that bullet?

C: It's unlikely that there was any significant tumbling action because that would usually result in a larger wound, if that were in fact an exit. If it were an entrance wound / anyone could make no conclusions.

P: Based on your view of the wound, are you able to tell us anything about the angle through which the object passed through the President?

C: Not from my view, alone.

P: From what evidence are you able to make what determination about the angle?

C: Only that /There was some injury to the trachea behind it, so the thing must have been going front to back, rather than right to left. That's about all you could say.

P: And you said you weren't able to make a determination about the angle, so presumably that means you were not able to say that it was from lower to higher or from higher to lower?

C: That's correct. I couldn't make any guesses about that.

P: Before the Warren Commission, you were asked a question which detailed a number of characteristics of damage through the President's body of a missile. I'd like to explore that hypothetical to see which of this evidence, if any, you know from personal knowledge and what you may know other sources. You were told to assume that the missile passed through the body of the President, striking no bones, traversing the neck and sliding between the large muscles in the posterior aspect of the President's body through a faschia channel without violating the pleural cavity. Based on the evidence as you knew it, did you have independent knowledge of this fact ?

C: No.

P: I'll continue. But bruising only the apex of the right plural cavity. Did you have independent evidence that the apex of the right plural cavity was damaged?

C: No... at this point, we're beginning to get into an area where I could at least have some knowledge that was compatible with that.

P: What knowledge would that be?

C: That we saw the bruising, the hematoma beside the trachea. But I still didn't know whether the pleural was bruised or not.

P: Could the pleural have been bruised?

C: Yes, certainly.

P: I'll continue: But bruising only the apex of the right plural cavity and bruising the most aevical portion of the right lung. Did you have independent knowledge that the most aevical portion of the right lung was bruised?

C: No

P: Did you have any other evidence which would indicate that it might be or that it was likely that it was?

C: Again, that hematoma was in the area would be compatible with that, but certainly wouldn't indicate any lung injury.

P: And continuing: then causing a hematoma to the right of the larynx, which you described. As you said before the Warren Commission, I'll ask you now, was the appearance of the wound in the anterior neck consistent with those facts?

C: Yes, certainly it's consistent.

P: Could you please continue with a /description of the treatment of the President after the insertion of the endotracheal tube.

C: After the endotracheal tube was inserted, as I said, the next step is to try to restore breathing -- an airway, then you try to restore the circulation. And we had adequate but not perfect ventilation. The next thing we tried to do was get the circulation going. There were already a couple of IV lines started by incisions in the ankle. Another one was being done in the arm. The President was getting fluids through those to try to get his blood pressure up. I don't know if blood had been started at that point or not. He was given some carto/ steroids, and Dr. Perry/and Dr. Jones took over the primary management and I started

making sure that the IVs, etc. were running properly.

P: They were dealing with the primary management of what portion?

C: They were calling the shots. They were overall quarterbacking of his care, which basically consisted of trying to get vital signs, vital functions going, breathing going, circulation going, and assess how bad his head injury was.

P: What was your primary emphasis at that time. Would it be fair to say that you moved on from consideration of the airway problem to one of the circulation?

C: Yes.

P: What happened then in regard to the airway problem? What did Dr Jones and Dr Perry do?

C: The ventilation appeared to be adequate, we could not get adequate circulation. Their concern was that conceivably there was either, because there was still leakage around the trachea, that either the tube was not functioning entirely properly, or that there was some pneumothorax, some pleural injury. So they performed a tracheostomy to assure an adequate airway and instructed some other physicians to insert chest tubes to try to rule out the possibility of any tension in the thorax which could impair his circulation also.

P: What evidence did you obtain from the chest tubes?

C: Again, this is second-hand, I didn't do this. But, when the chest tubes were inserted, there was a small amount of blood,

and small amount of air, which could have resulted from the actual surgical manipulations or could conceivably have been commensurate or compatible with some very small pneumothorax or hemothorax. But basically the chest tubes did not show any signs of massive injury and did not in their insertion didn't improve the situation.

P: Did you have sufficient facts from which you could conclude that the pleural cavity was violated?

C: No, we did not.

P: Did you believe it was likely that the pleural cavity was violated?

C: We felt there was a high risk that it had been. After the chest tubes were inserted, we were sure that it was no longer potentially harmful to his life. But we still didn't know for sure whether it had been violated or not.

P: Do you have an opinion as to why there was leakage from the wound?

C: After the tube was inserted? I really don't. There are two fairly good possibilities. One is that the balloon was not completely through his trachea, either because it was not down quite far enough, or it was not blown up quite enough. Those are the two possibilities that would be most likely.

P: Why was President Kennedy given steroids?

C: Because we had, there had been an argument in the local papers a few weeks previously that raised the question of whether or

not he had adrenal insufficiency. If one does have adrenal insufficiency and is injured, then you need extra steroids.

P: If there any risk to giving the person extra steroids if they don't need it?

C: Very little. Virtually none. Matter of fact, the amount he was given is the amount that your or my adrenals would excrete in time of maximum stress.

P: How harmful would it be for a person with an adrenal insufficiency not to get steroids at a time like this?

C: Nobody really knows. The current medical opinion is that you need that adrenal support to respond to the stress. And without that kind of support, one could go into shock. If one really wants to get esoteric, you can argue about whether that's really true or not. But in general, the current medical practice would be to give them. And if one were going to do an operation on someone with adrenal insufficiency, you would give steroids prior to enduring the operation.

P: Did Dr. Berkeley give you any advice as to whether or not steroids should be given?

C: Sometime during the course of resuscitation, and I've honestly forgotten how far along, he came in, asked if the President had steroids or not, I answered something like - I've forgotten what. He handed me some vials and said, "give him these."

P: Did you give him those?

C: I handed those to the nurse, and said "go ahead and give them."

P: Did Dr. Berkeley say that President Kennedy was an Addisonian?

C: I don't recall him saying that. He just asked if he'd had them or not and I answered in the affirmative.

P: Do you remember any discussion about whether he was an Addisonian?

C: I really did not hear any other discussion.

P: Did you witness the tracheostomy incision?

C: No, not directly.

P: Do you know why the tracheostomy incision was made?

C: Basically because there was concern that the ventilation through the endotracheal tube was conceivably not adequate. It was leaking and he wasn't doing well.

P: Did the procedure giving the tracheostomy incision give you a further look at the nature of the anterior neck wound of the President.

C: It did not give me any further look. I was not involved.

P: Did you see the anterior neck area subsequent to the tracheostomy incision?

C: No, I did not.

P: After the tube would be put into the tracheostomy incision, to what extent, if any, would a wound, or could a wound in that area be obscured?

C: Because of the nature of most tracheostomy tubes, the incision would almost totally be obscured. There is a flange over, near the mouth of the treacheostomy tube that covers most treacheostomy incisions.

P: Is it your recollection that this tube in question had such a feature?

C: I would almost be sure it did. That's from memory of tubes more than that specific technique used.

P: Did you have any evidence which would indicate that one of the President's transverse processes was fractured?

C: No, I didn't.

P: Did you have any evidence which would indicate that it was unlikely that this was the case?

C: No.

P: Would a fracture of the transverse process be inconsistent with a bullet exiting through the front of the neck as you've described the nature of the wound?

C: I don't think so. It's unlikely that a missile would have gone through the body of a transverse process and not have lost more energy than this thing apparently lost. But it certainly could have chipped one or nicked it or something like that, and not have made much difference.

P: Could you briefly describe for us the nature of the wound in the President's head?

C: The head wound was a much larger wound than the neck wound. It was five by seven centimeters, something like that, 2½ by 3 inches, ragged, had blood and hair all around it, located in the part of the parietal occipital region,

P: Could you just state in layman's terms the approximate place that would be.

C: That would be above and posterior to the ear, almost from the crown of the head, there was brain tissue showing through.

P: Would the neck wound, by itself, have been fatal?

C: No, I do not think so. I think that was a recoverable wound.

P: You think it was unlikely that it would have been fatal. Would the neck wound have permanently impaired the President's speech?

C: I don't believe so.

P: Would it have impaired the President's speech so that he could not have spoken in the Presidential limousine just after he was injured?

C: It would have made it difficult. There would have been an air leak from the trachea and it would have been difficult for him to speak in a natural fashion, with great effort he might have formed some words.

P: As one of the attending physicians, were you, was it inconsistent with normal procedure that you were not contacted by the autopsy surgeons?

C: Not really, because I was fairly far down the ladder, in being a resident. Dr Perry was above me, Dr Jones was above me. Had the autopsy been done by the forensic pathologist in Dallas, he would almost have certainly have consulted one of the attending physicians. When autopsies were done elsewhere, we ordinarily had requests for that, like you say what was routine.

P: Did you or any of the other doctors consider initiating a contact with the autopsy surgeons about what you had seen and done?

C: I did not. I don't know if any of the other doctors did or not. We did write our handwritten notes which we assumed would be transmitted with the President, either to the forensic pathothologist there or wherever. And, as I think of it, I'm not sure we were aware until some time later that they had not been.

P: Were you surprised that none of the attending physicians were in communication with the autopsy surgeons prior to the completion of the autopsy?

C: I don't guess surprised is the word. As I think back, trying to remember, I guess we assumed

(tape running while interview interrupted)

C: You asked me, was I surprised that the autopsy were not in communication with any of the attending physicians. As I say, I guess, I remember we assumed those written documents had gone to whoever was doing the autopsy, and had it been done by Dr. Rose. I think he would have contacted somebody. So I guess the best thing to say is that there was certainly limited information available to the guy who did the autopsy, and I think in general there would have been some contact, had the geography been a little closer.

P: Do you have any additional comments or points that you feel have been misstated in the record or you feel that should be cleared up, that you'd like to comment on at this time?

C: I don't believe so.

P: Do you have anything else you'd like to add to your descriptions of the wounds as you described them for this tape?

C: Only the fact that the thing we talked about earlier is that there's a big difference in what you look for for patient care and for forensics, and that we were looking for patient care. And you basically see what you look for, and we were not looking to try to determine whether this was an entrance or exit wound, anymore than we needed to know to try to determine what the life threatening complications or results of that injury might have been. So we didn't look to see where the missile came from, what it's direction was, whether it was an exit wound or not.

P: This taping session is now over. Time is 3:20.